

CONTACT INVESTIGATIONS UPDATES



Virginia Department of Health Division of Tuberculosis (TB) Control ~ TB Contact Investigation Summary Form (TB 502)

Index Case ID # _____	District _____	Nurse Case Manager Name _____	Nurse Case Manager Phone # _____	Infectious Period		
Date Case/Suspect Reported to Local Health Department _____				Date Contact Investigation Initiated _____	Start Date: _____	End Date: _____
Type of Investigation: <input type="checkbox"/> Contact <input type="checkbox"/> Source Case Type of Case/Suspect: <input type="checkbox"/> Pulmonary Smear Pos. <input type="checkbox"/> Pulmonary Culture Pos. <input type="checkbox"/> Pulmonary Smear Neg. <input type="checkbox"/> Extrapulmonary <input type="checkbox"/> Clinical <input type="checkbox"/> GeneXpert Pos.						

<p>Contact Last Name: _____ Contact First Name: _____</p> <p>DOB: _____ Race/Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic</p> <p>Sex: _____</p> <p>Address: _____</p> <p>Contact Relationship to Case: <input type="checkbox"/> Household <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Place of Worship <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office <input type="checkbox"/> Social Setting <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Other (if other please specify): _____</p> <p>Date of last exposure to the case: _____</p>	<p>Priority <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> <p>Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list: _____ _____ _____</p>	<p>Hx of Prior (+) TST or TB disease <input type="checkbox"/> LTBI <input type="checkbox"/> TB Disease</p> <p>Hx of Prior treatment for LTBI <input type="checkbox"/> Completed treatment <input type="checkbox"/> Partially treated <input type="checkbox"/> Never treated <input type="checkbox"/> Unknown</p>	<p>LTBI Test Used: <input type="checkbox"/> TST <input type="checkbox"/> IGRA</p> <p>Round 1: Date tested: _____ Result: <input type="checkbox"/> mm if TST <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Indeterminate/Borderline</p> <p>Round 2: Date tested: _____ Result: <input type="checkbox"/> mm if TST <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Indeterminate/Borderline</p>	<p>CXR Date: _____</p> <p>CXR Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Cavitory <input type="checkbox"/> Non. Cavitory</p>	<p>TB Case? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>LTBI Tx Recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: Tx Type: _____ Comments: _____</p> <p>Date Tx Started: _____</p> <p>Date Tx Stopped: _____</p> <p>Treatment Stop Reason: <input type="checkbox"/> Completed Therapy <input type="checkbox"/> Death <input type="checkbox"/> Moved (follow-up unknown) <input type="checkbox"/> Active TB developed <input type="checkbox"/> Adverse effects of medication <input type="checkbox"/> Chose to stop <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Provider decision</p>
--	--	---	---	---	---

<p>Contact Last Name: _____ Contact First Name: _____</p> <p>DOB: _____ Race/Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic</p> <p>Sex: _____</p> <p>Address: _____</p> <p>Contact Relationship to Case: <input type="checkbox"/> Household <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Place of Worship <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office <input type="checkbox"/> Social Setting <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Other (if other please specify): _____</p> <p>Date of last exposure to the case: _____</p>	<p>Priority <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> <p>Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list: _____ _____ _____</p>	<p>Hx of Prior (+) TST or TB disease <input type="checkbox"/> LTBI <input type="checkbox"/> TB Disease</p> <p>Hx of Prior treatment for LTBI <input type="checkbox"/> Completed treatment <input type="checkbox"/> Partially treated <input type="checkbox"/> Never treated <input type="checkbox"/> Unknown</p>	<p>LTBI Test Used: <input type="checkbox"/> TST <input type="checkbox"/> IGRA</p> <p>Round 1: Date tested: _____ Result: <input type="checkbox"/> mm if TST <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Indeterminate/Borderline</p> <p>Round 2: Date tested: _____ Result: <input type="checkbox"/> mm if TST <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Indeterminate/Borderline</p>	<p>CXR Date: _____</p> <p>CXR Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Cavitory <input type="checkbox"/> Non. Cavitory</p>	<p>TB Case? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>LTBI Tx Recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: Tx Type: _____ Comments: _____</p> <p>Date Tx Started: _____</p> <p>Date Tx Stopped: _____</p> <p>Treatment Stop Reason: <input type="checkbox"/> Completed Therapy <input type="checkbox"/> Death <input type="checkbox"/> Moved (follow-up unknown) <input type="checkbox"/> Active TB developed <input type="checkbox"/> Adverse effects of medication <input type="checkbox"/> Chose to stop <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Provider decision</p>
--	--	---	---	---	---

<p>Contact Last Name: _____ Contact First Name: _____</p> <p>DOB: _____ Race/Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic</p> <p>Sex: _____</p> <p>Address: _____</p> <p>Contact Relationship to Case: <input type="checkbox"/> Household <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Place of Worship <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office <input type="checkbox"/> Social Setting <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Other (if other please specify): _____</p> <p>Date of last exposure to the case: _____</p>	<p>Priority <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> <p>Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list: _____ _____ _____</p>	<p>Hx of Prior (+) TST or TB disease <input type="checkbox"/> LTBI <input type="checkbox"/> TB Disease</p> <p>Hx of Prior treatment for LTBI <input type="checkbox"/> Completed treatment <input type="checkbox"/> Partially treated <input type="checkbox"/> Never treated <input type="checkbox"/> Unknown</p>	<p>LTBI Test Used: <input type="checkbox"/> TST <input type="checkbox"/> IGRA</p> <p>Round 1: Date tested: _____ Result: <input type="checkbox"/> mm if TST <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Indeterminate/Borderline</p> <p>Round 2: Date tested: _____ Result: <input type="checkbox"/> mm if TST <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Indeterminate/Borderline</p>	<p>CXR Date: _____</p> <p>CXR Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Cavitory <input type="checkbox"/> Non. Cavitory</p>	<p>TB Case? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>LTBI Tx Recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes: Tx Type: _____ Comments: _____</p> <p>Date Tx Started: _____</p> <p>Date Tx Stopped: _____</p> <p>Treatment Stop Reason: <input type="checkbox"/> Completed Therapy <input type="checkbox"/> Death <input type="checkbox"/> Moved (follow-up unknown) <input type="checkbox"/> Active TB developed <input type="checkbox"/> Adverse effects of medication <input type="checkbox"/> Chose to stop <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Provider decision</p>
--	--	---	---	---	---

Instructions for Tuberculosis Contact Investigation Submission (502)

Initial Submission: Submit the initial CI information using the online submission tool
Submit the initial information within 4 weeks of CI initiation

Final Submission: Submit the fillable/printable 502 with patient specific information, including LTBI tx information
Submit the final 502 after the investigation is complete

*Please note, we are no longer asking for the 502 to be submitted three times; we are only asking for the initial online summary submission and the final faxed or encrypted e-mail submission.

Access the electronic initial submission form via the link available on the TB Control Website [Contact Investigations Page](#)

All fields on the electronic initial submission form are required except for Infectious Period End Date

Please complete and submit this form within 4 weeks of contact investigation initiation.

Index Case Last Name	Provide the last name of the index case	<input type="text"/>
Index Case First Name	Provide the first name of the index case	<input type="text"/>
Index Case ID Number	Provide a patient ID number such as a Webvision or Avatar ID number	<input type="text"/>
Index Case Date of Birth	Provide the date of birth of the index case. You can directly type in a date with or without dashes	<input type="text"/> <input type="text"/> <input type="text"/> Today M.D.Y
District	Use the drop down to select the submitting health district/location. Type to search.	<input type="text"/>
Nurse Case Manager Name	Provide the name of the nurse case manager for the contact investigation	<input type="text"/>
Nurse Case Manager Phone Number	Provide a contact number for the nurse case manager for the contact investigation	<input type="text"/>
Date Case/Suspect Reported to Local Health Department	Indicate the date the LHD first became aware of the index case	<input type="text"/>
Date Contact Investigation Initiated	Indicate the date the contact investigation was initiated	<input type="text"/>
Type of Investigation	Select if this is a Contact or Source investigation	<input type="radio"/> Contact <input type="radio"/> Source
Type of Case/Suspect	Select all options that apply to the index case based on the information you have at the time of submission	<input type="checkbox"/> Pulmonary Smear + <input type="checkbox"/> Pulmonary Culture + <input type="checkbox"/> Pulmonary Smear - <input type="checkbox"/> Pulmonary GeneXpert + <input type="checkbox"/> Clinical <input type="checkbox"/> Extrapulmonary

Please select all that apply

502 Initial Submission:

- Submit the initial CI information using the online submission tool
- Submit the initial information within 4 weeks of CI initiation

502 Final Submission:

- Submit the fillable/printable 502 with patient specific information, including LTBI tx information
- Submit the final 502 after the investigation is complete

We are no longer asking for the 502 to be submitted three times; we are only asking for the initial online summary submission and the final faxed or encrypted e-mail submission

Instructions for Tuberculosis Contact Investigation Initial Submission (502)

Infectious Period Start Date <small>* must provide value</small>	Indicate the infectious period start date for the index case	<input type="text"/> Today M-D-Y
Infectious Period End Date	If the information is available, indicate the infectious period end date	<input type="text"/> Today M-D-Y <small>noun</small>
With what information you know now, are there children under 5 identified as contacts? <small>* must provide value</small>	<input type="radio"/> Yes <input type="radio"/> No	Indicate if there are any children under 5 who might need window prophylaxis <small>reset</small>
Select the location(s) identified for the contact investigation. <small>* must provide value</small>	<input type="checkbox"/> Household <input type="checkbox"/> School <input type="checkbox"/> Workplace <input type="checkbox"/> Place of Worship <input type="checkbox"/> Hospital <input type="checkbox"/> Medical Office <input type="checkbox"/> Social Setting <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Shelter <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Other	Select ALL locations where a contact investigation will be conducted If you select "other" a text box will appear to provide additional location information <small>Please select all that apply.</small>
Provide additional information or clarify a response if needed.	Use this space to provide any additional information	<input type="text"/> <small>Expand</small>
Hit "Submit" once you have completed the form. If you left a required field blank, you will be prompted to complete it.	<input type="button" value="Submit"/>	Click here if you want to return later to complete the form. The system will give you a return code to access your saved work. <input type="button" value="Save & Return Later"/>
<input type="button" value="Close survey"/> Thank you for submitting initial contact investigation information. Please submit the 502 form as soon as possible upon completing the contact investigation once all information is available.	<input type="button" value="Download"/>	After hitting "Submit," a box will appear confirming your submission. To download the form for your records or for printing, click the "Download" button and a PDF version of the form will display.

PLEASE SUBMIT YOUR FINAL 502 WITH PATIENT SPECIFIC INFORMATION AS SOON AS POSSIBLE UPON COMPLETION OF THE CONTACT INVESTIGATION

Recommendations for Assigning Priority to Contacts based on Cumulative Environmental Exposure during the Infectious Period

Space size	Exposure Site	High Priority	Medium Priority	Low Priority
Very small	Car, small office, 150 sq. ft. 12 x 12=144 sq. ft.	8 or more hours	4 to less than 8 hours	Less than 4 hours
Small/medium	Classroom, meeting room 25 x 25=600 sq. ft.	24 or more hours	8 to less than 24 hours	Less than 8 hours
Medium/large	Cafeteria, small church 36 x 36=1296 sq. ft.	50 or more hours	24 to less than 50 hours	Less than 24 hours
Large	Gymnasium, auditorium 50 x 50-2400 sq. ft.	100 or more hours	50 to less than 100 hours	Less than 50 hours

Fewer hours exposed → lower potential for transmission → lower priority for evaluation

Factors Determining Transmission

- Infectiousness of Case
- Duration of Exposure
- Environmental Conditions
- Susceptibility of Contact

Infectiousness of Case

- Smear Results (Fluorochrome stain)
- Negative No AFB Seen
- +/- 1-2 AFB/30 Fields
- 1+ 1-9 AFB/10 Fields
- 2+ 1-9 AFB/Field
- 3+ 10-90 AFB/Field
- 4+ >90 AFB/Field

Environmental conditions

- Size of Environment
- Amount of ventilation
- Location of vents
- Directional flow around index

Duration of Exposure

- Exposure Limits -High Priority
- 8 hrs very small space
- 24 hrs small-medium space
- 50 hrs medium-large space
- 100 hrs large space

Susceptibility of Contact

- Current Immune Status
 - Immune Suppressive Medication
 - HIV Status
 - Other medical co-morbidities
- Substance Abuse
- Malnutrition
- Age

Kandor Nursing Home and Dialysis Center

The index is 88 y/o Lana. She has resided at the Kandor NS for approximately 3 years. She has a single suite with no roommate. She is ambulatory, and readily participates in daily activities.

Sputum Smear **1+**

Chest X-Ray **Cavitary**

No symptoms noted by staff

What else do we need to know?

LEXCORP & STAR LABS

Today's date is Sept 27th

The case is 28 y/o male scientist Ray

Sputum Smear **4+**

Chest x-ray: Bilateral Cavitory

Symptoms began **May 15th**

Index worked at Lexcorp for three years, leaving on **July 1st**. Began employment at Star Labs on **July 8th**.

No household or social contacts identified

At LexCorp Ray worked in cubicle # 2233 on the 2nd floor. There are 10 floors with 900 cubicles on each, and 100 offices with doors. Cubicle #2233 is located on the East side of the building, 4th row from the wall, 1/3rd distance from the front of the room.

At Star Labs, Ray managed a team of 100 employees. He did have an office with a door, and met daily with his 10 team leaders for approximately **1 hour**.

METROPOLIS MIDDLE SCHOOL

Today's date is **Oct. 17th**

Last day at school **Oct. 16th**

The school year began on Tuesday **Sept. 3rd**

Index is a 14-year-old US born male. His summer was spent with extended family outside of the United States.

Sputum smear **2+**

CXR RUL patchy infiltrate, Hilar lymph

HOUSEHOLD Contacts:

Father George 40 y/o TST negative

Mother Martha 39 y/o TST negative

Cousin Kara 16 y/o TST negative

Brother 12 y/o TST positive

Brother 4 y/o TST positive

SCHOOL Contacts:

Best Friends: Bruce 14 Y/o TST Positive, Jimmy 14 y/o TST Positive

Girlfriend: Lois 14 y/o TST negative

CHEMISTRY CLASS: 45' X 42' MWF 1 hour each **30 students**

HISTORY CLASS: 25' X 30' TTH 1.5 hours each **25 students**

ENGLISH CLASS: 33' X 28' MWF 1hour each **28 students**

TRIGONOMETRY CLASS: 20' X 24' MWF 1hour each **19 students**

SOCIAL MEDIA CLASS: 35' X 20' TTH 1.5 hours each **35 students**

GYM: locker room, gymnasium, outdoors M-F 1 hour each **28 students**